(41) (39)

Nos. 95-1858, 96-110

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writ Of Certiorari To The United States Courts Of Appeals For The Second And Ninth Circuits

BRIEF OF *AMICI CURIAE* CHRISTIAN LEGAL SOCIETY, CHRISTIAN MEDICAL AND DENTAL SOCIETY, CHRISTIAN PHARMACISTS FELLOWSHIP INTERNATIONAL, NURSES CHRISTIAN FELLOWSHIP, AND FELLOWSHIP OF CHRISTIAN PHYSICIAN ASSISTANTS IN SUPPORT OF PETITIONERS

EDWARD J. LARSON *
KIMBERLEE WOOD COLBY
STEVEN T. MCFARLAND
Center for Law and Religious Freedom
Christian Legal Society
4208 Evergreen Lane, Suite 222
Annandale, Virginia 22003
703-642-1070

**Counsel of Record*

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

41 PP

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

Page

TABLE OF AUTHORITIES – Continued

Page

TABLE OF AUTHORITIES – Continued

Page

TABLE OF AUTHORITIES – Continued

Page

INTEREST OF THE *AMICI CURIAE*

The interest of each *amicus curiae* is set forth in the Appendix to this brief. The letters from the parties consenting to the filing of this brief have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

In the rush to divine a new constitutional right to physician-assisted suicide, the courts below failed to give adequate consideration to the consciences of the many health professionals who will be forced to participate in physician-assisted suicide. The decisions below will radically change the health care system into one in which health professionals routinely will be called upon to implement physician-assisted suicide. Many health professionals will find themselves coerced into some degree of involvement in the intentional killing of patients, including patients who are incompetent and not terminally ill.[1]

---

[1] Importantly, the context of "physician-assisted suicide" is not limited to situations in which a competent, terminally ill patient makes his or her own decision to terminate his or her life and seeks from the health care professional "only" the means of doing so. As the Ninth Circuit made clear in *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996), its ruling would not be limited to situations in which the patients would self-administer the fatal drug dosage, but would extend as well to patients who are not terminally ill but in a persistent vegetative condition, as well as patients whose guardians make the decision to have a fatal drug dosage administered to the patient. *See, e.g.*, Wash.App. A99 (definition of terminal illness "includes persons who are permanently unconscious, that is in an irreversible coma or a persistent vegetative state"); A100-101 ("recogniz[ing] that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them"

Amici include health care professionals who have substantial reason to believe that they will be subject to significant pressure from supervisors, insurance companies, employers (including managed care associations, nursing homes, and hospitals) to participate in the administration of fatal drug dosages to patients. *Amici* have religious convictions against enabling others to kill themselves, as well as against killing patients, whether or not the patient has consented to the killing.

Contrary to popular belief, individual physicians on staff at a hospital, health clinic, nursing home, or managed care organization often do not have sufficient autonomy to make medical decisions that carry significant economic costs for their employers. Employers who are concerned about a profitable bottom-line are unlikely to allow employee health professionals the requisite scope to obey their religious convictions, when the employers will be bearing the economic cost of the employees' inconvenient religious convictions. Part I briefly describes a sampling of realistic scenarios in which objecting physicians, medical students, nurses, pharmacists, and other health care professionals will find it virtually

---

but denying that issue was being decided); *id.* n.120 ("Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.").

The court did not address specifically how one person choosing death for another is suicide or how a patient incompetent to make such a decision would be competent to administer the lethal dosage of medicine to herself. Clearly, when the patient cannot self-administer the fatal dosage, someone will be required to do so, and often that person will be the physician or nurse attending the patient.

For purposes of this brief, "Wash.App." will refer to the Appendix to Petition for Writ of Certiorari in *State of Washington v. Glucksberg*, No. 96-110, and "N.Y.App." will refer to the Appendix to Petition for Writ of Certiorari in *Vacco v. Quill*, No. 95-1858.

impossible to avoid participation in physician-assisted suicide. For example, physicians likely will be required to justify, to their employers or insurance companies, a decision not to provide fatal drug dosages to terminally ill patients. Physicians will be asked to provide suicide assistance to patients unable to make such a decision for themselves but whose legal guardian desires a fatal dosage to be administered.

Nor will physician-assisted suicide affect only the patient and doctor. A nurse is likely to be the agent required to administer the fatal dosages, just as he or she is the person who administers most medications to patients in hospitals, clinics, and nursing homes. The ordering physician is unlikely to be sensitive to a nurse's failure to "carry out orders," particularly when the physician is likely to perceive the nurse's refusal as an implicit condemnation of the physician's own morality.

In medical school or residency, medical students may be required to learn, using real patients, how to administer fatal dosages in the proper strength and manner. Medical facilities that refuse to provide such training may be threatened with a loss of accreditation.

The decisions below fail to recognize the legitimate concerns of numerous health professionals who are prohibited by religious convictions from intentionally killing another human being or assisting another person in committing suicide. One effect of the decisions below may be a further decrease in the availability of health care professionals, as many doctors and nurses are driven out of their chosen profession and many students forego medical careers, simply because they cannot participate in a health care system in which physician-assisted suicide is impossible to avoid in real-life terms.

Part II describes the fundamental legal errors in the decisions below. Both courts wrongly equated termination of life-sustaining medical treatment with the affirmative prescription of lethal medication. Yet the common law, numerous state laws, several judicial opinions, and leading medical authorities all recognize that there is a

critical distinction between a decision to stop treatment and a decision to administer deadly drug dosages.

In Part III, *amici* refute the Ninth Circuit's assertion that tradition and history support the right to assisted suicide. Contrary to the Ninth Circuit's interpretation of Biblical accounts of individuals committing suicide, there has been no acceptance of suicide as moral within the historical Christian tradition. Instead, the early Church condemned "self-murder." National and Washington State history also do not support a right to commit suicide.

ARGUMENT

I. Physician-Assisted Suicide Will Profoundly Affect the Ability to Obtain and Retain Employment for Health Care Professionals Who Have Religious Convictions Against the Intentional Killing of Oneself or Other Human Beings.

A. Contrary to the decisions below, health care professionals with religious convictions against killing other persons will not be able to avoid the widespread effects on the health care system of physician-assisted suicide.

At its core, the practice of medicine is based on a relationship – the relationship between the patient and the physician. Both have a moral stance in the relationship, with external and internal pressures acting upon each. The discussion regarding physician-assisted suicide in the decisions below focused almost exclusively on the patient's desires, needs, or rights. However, even if a legitimate case could be made for the need of the patient to be assisted by a physician in committing suicide, it is still necessary to examine the interests and needs of the other party to the relationship – the physician.

Legalizing physician-assisted suicide is certain to affect physicians who object for religious reasons to the intentional termination of another human being's life. For

legal as well as economic reasons, physicians will find it increasingly difficult to refuse to assist patients in committing suicide. Once legalized, the practice of physician-assisted suicide will become the norm, the standard of care expected from a physician. It is likely that a positive duty to perform this "service," and assist patients to commit suicide, will be recognized and become a potential source of malpractice claims against physicians who refuse to perform physician-assisted suicides. Physicians with religious objections to killing oneself or other human beings will be forced either to aid directly in suicide or, at a minimum, to be an accomplice to the suicide by arranging referrals to physicians who are willing to participate. Under some forms of managed care organizations, physicians who refuse to assist a patient in killing himself are likely to be required to pay another physician's charges for killing the patient.

Scenario 1: Dr. Smith is a primary care physician working in a managed care organization. The organization uses a strict capitation model for care, in which patients initially see their primary physician for all complaints and are referred to a specialist only if the primary physician feels it is necessary. The physician must certify the need and authorize the funding for this care. The organization adopts this model of care in order to decrease expenditures for specialty care and realizes a profit only if actual expenditures are less than or equal to those planned for during the term of the contract with the physician. Physicians who repeatedly exceed their "caps" are unlikely to have their contracts renewed.

Dr. Smith evaluates a patient with AIDS, who is still likely to live a considerable length of time but who requests Dr. Smith's assistance in committing suicide now. Dr. Smith considers the likely expenses involved in providing care for this patient if the patient chooses maximal therapy over the next months and years, as opposed to the expenses incurred if the patient commits suicide within the month.

Recognizing that maximal therapy will greatly exceed the cap for this patient, Dr. Smith is nonetheless unable for religious reasons to participate in the suicide herself or to refer the patient to another physician. As a result of this decision, Dr. Smith is likely to face several crises involving coercion of conscience:

1) May her employer, the managed care organization, require her to refer the patient to a physician willing to help him commit suicide?

2) If Dr. Smith is bypassed and someone else in the managed care organization refers the patient to a physician who will assist him in committing suicide, may the employer, the managed care organization, require Dr. Smith to pay for the expenditure for the suicide procedure from her own account?

3) Given that the option for physician-assisted suicide is better financially for the managed care organization, may the organization require its employee Dr. Smith to inform all her HIV-positive patients about the option of physician-assisted suicide?[2]

4) Will Dr. Smith's "mix" of patients change, making her more likely to exceed her overall "cap," with the attending economic consequences for her practice and the likelihood that her contract with her employer will not be renewed?

5) May the managed care organization require Dr. Smith to inform all her patients, even those without lethal illnesses, of the option of physician-assisted suicide, in

---

[2] Merely raising the option may suggest to a patient that " 'his or her life was not worth living, a message that would have a powerful effect on the patient's outlook and decision.' " Chairman Charles T. Canady, Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess., *Physician-Assisted Suicide and Euthanasia in the Netherlands* 9 (Comm. Print 1996) (hereinafter "*Physician-Assisted Suicide* Report") (quoting testimony by hearing witness psychiatrist Dr. Herbert Hendin on the prevalence of doctors in the Netherlands who initiate the idea of euthanasia as a treatment option with their patients).

order for them to include the option in their advance written directives?

6) May Dr. Smith be required to record in a patient's records an advance written directive requesting physician-assisted suicide?[3]

Physician-assisted suicide will also harm nurses, medical students, pharmacists, and other health care providers with religious objections to the intentional killing of other human beings. As the following scenarios illustrate, "[n]urses and many other health care workers are particularly vulnerable to pressure because they occupy subordinate positions in the hospital/medical hierarchy." Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. Legal Med. 177, 220 (1993).

Scenario 2: Nurse Doe is the registered nurse responsible for the medical/surgical floor in a small community hospital. A patient on the floor, who is unable to move or feed himself, requests his physician's assistance in committing suicide. The physician agrees to the patient's request and writes in the patient's chart the order for the patient to be given a lethal dosage of medicine.

Due to her religious convictions, Nurse Doe is opposed to the intentional killing of another human being. Therefore, she informs the physician that she will not administer the lethal dosage of medicine to the patient that the physician has ordered. The physician angrily states that he will administer the drug himself. He

---

[3] *Cf.*, The Federal Patient Self-Determination Act, 42 U.S.C.A. § 1395cc(f) (West 1992 & Supp. 1995) (requiring all health care providers receiving Medicaid or Medicare to inform patients about state laws regarding advance directives to refuse life-sustaining treatment and to record any advance directive of the patient). If the decisions below are affirmed, it is not difficult to anticipate that the federal government might require all physicians to record patients' advance directives regarding physician-assisted suicide.

orders Nurse Doe to open the controlled substance cabinet to which she has the key. Nurse Doe is unwilling to assist in the suicide at all.

Nurse Doe faces repercussions for her refusal to participate in the suicide, including:

1) May the physician file a complaint against her for refusing to carry out his orders?

2) May her supervisor take her refusal into consideration in her annual evaluation and in decisions regarding pay raises?

3) Must she abandon hospital nursing in order to avoid similar situations in the future as physician-assisted suicide becomes increasingly widespread?

This scenario is based on the Ninth Circuit's acknowledgment that "in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, *or a person acting under his direction or control*, may be the only way the patient may be able to receive them." Wash.App A100 (emphasis added).

The nurse's role in assisting patients to commit suicide is the subject of the highly instructive *Guidelines for Euthanasia*, promulgated by medical groups in the Netherlands, "in regard to cooperation and job demarcation of doctors/nurses and aids in procedures relating to euthanasia." Royal Netherlands Society for the Promotion of Medicine and Recovery, Interest Association of Nurses and Nursing Aids, *Guidelines for Euthanasia, reprinted in* 3 Issues in Law and Medicine 429 (1988) (Walter Lagerwey trans.). The Guidelines concede that euthanasia has engendered problems between nurses and physicians:

> Lack of clarity in respect to tasks, competences, and responsibilities of doctors on the one hand and nursing personnel and aids on the other, with regard to euthanasia, gives rise to conflicts and dissension in daily practice.

Id. at 429-430.

While claiming that "euthanasia, if it occurs, is performed by a doctor," *id.*, the Guidelines "realize that there

is a discrepancy between the content of these guidelines, in which it is posited that only a doctor shall be entrusted with the carrying out of euthanasia and *actual every day practice in which nursing attendants and aids are often directly involved in euthanasia activities.*" *Id.* at 435 (emphasis added).

The Guidelines recognize that nurses will often receive the initial request for euthanasia. *Id.* at 433. In cases where the doctor has decided to carry out euthanasia, "[i]f the nursing and caring attendant has [sic] doubts about the manner in which the standards of appropriate medical care are carried out," the Guidelines direct the nurse to talk to the doctor. If the nurse still "continues to have serious doubts after receiving information from the doctor," she may consult a second physician or seek the "mediation of the nursing head of the division or directors of the institution," but she must inform both the patient and the attending doctor before she does any of the above. *Id.* at 434-435.[4]

As the primary direct caregivers to patients, nurses necessarily will be the persons most affected by the implementation of assisted suicide in hospitals and nursing homes. They are also the persons least likely to have sufficient influence or authority to be able to avoid complicity in assisting patients to commit suicide. The decisions below will force many nurses into an untenable

---

[4] The Guidelines provide that doctors and nurses who have conscientious objections to euthanasia may refuse to participate in the process. But they must also not participate in the *initial* decisionmaking process "because then there can be no question of an objective participation in the decision for euthanasia." *Id.* at 436. That is, an anti-euthanasia physician's participation in the euthanasia decisionmaking process biases the process, but participation by a pro-euthanasia physician does not. If a conscientious objector is the first person to hear the patient's request, "he is (morally) obligated to inform the patient of his view of euthanasia" and "give the patient the opportunity to contact another provider of assistance." *Id.*

position, forcing them either to violate their religious convictions against taking the life of another human being or to forfeit their jobs.

Scenario 3: Dr. Jones has been the physician attending the patients at a small nursing home owned and operated by a religious corporation. The religious tenets of the religious corporation prohibit the intentional taking of human life by oneself or by another. A patient in the nursing home, who has a terminal illness, requests that Dr. Jones assist her in committing suicide. Dr. Jones' religious convictions prohibit both the intentional taking of another human being's life and referral of the patient to a colleague who he knows will assist her in committing suicide.

1) May the patient or her family sue Dr. Jones for refusing to accede to her request for assistance in committing suicide?

2) Must the religious corporation allow physician-assisted suicide for its patients who request it, even though its religious tenets prohibit such conduct?[5]

---

[5] Some long-term care facilities have been required by judicial decrees to withdraw feeding and hydration tubes from patients despite the religious or moral objections of the institutions and their employees to withdrawal of life support. *See, e.g., Gary v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988) (hospital ordered to remove feeding/hydration tube of patient in persistent vegetative condition unless patient could be promptly transferred to another facility); *Matter of Jobes*, 529 A.2d 434, 450-451 (N.J. 1987) (private nursing home prohibited from transferring patient to another institution and ordered to withdraw feeding/hydration tube from incompetent patient despite moral opposition of the institution and its employees). *See also*, Wardle, *supra*, at 211-215.

3) Must the physician or the religious corporation transfer the patient to a facility that will perform physician-assisted suicide?[6]

Scenario 4: Pharmacist Johnson is on duty in the only pharmacy in town. He is filling a prescription for a large amount of barbiturates for a patient he knows to have a terminal illness. Because of the quantity and strength of the prescription, Mr. Johnson is reasonably certain that the drug will be used to terminate the patient's life. His religious convictions will not allow him to participate in a suicide. Mr. Johnson faces several issues as he ponders the situation, including:

1) Is it permissible for him to question the patient about the intended use of the prescription?

2) Is it permissible for him to discuss his concerns with the prescribing physician?

3) May the pharmacy owner require the pharmacist to fill the prescription, or would such an order be a

---

[6] Defeated by Washington State voters at referendum in 1991, Initiative Measure 119 would have permitted physician-assisted suicide in Washington State. It explicitly stated that objecting physicians would not be criminally or civilly liable if they refused to assist patients in committing suicide. However, it also explicitly required the objecting physician or health care facility to make a good faith effort to transfer the patient to another physician or facility that would terminate his life. Wash.App. H8-9.

The Uniform Health-Care Decisions Act, approved by the National Conference of Commissioners on Uniform State Laws in 1993, requires a health-care provider to comply with an individual's health-care decision unless the provider declines for reasons of conscience. If the provider or institution declines for reasons of conscience, the patient must be promptly informed and the provider or institution must "immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision." Uniform Health-Care Decisions Act § 7(e)-(g), 9 U.L.A. 220, 239 (1993).

violation of Title VII of the 1964 Civil Rights Act, or applicable state laws, prohibiting discrimination against religious employees?[7]

4) If so, what would constitute a "reasonable accommodation" of the religious employee's refusal to participate in a suicide?

5) If the pharmacy adopts a policy of not filling prescriptions that the pharmacist reasonably believes might be used to commit suicide, will this lack of "service" make it less likely that the pharmacy will be chosen to participate in major health care plans that accept, even promote, physician-assisted suicide as a form of "treatment"?

Scenario 5: St. Mary Hospital is a healthcare and teaching hospital offering medical residency training programs, including programs in geriatrics, oncology, and AIDS treatment. St. Mary adheres to the directives of its sponsoring church, which prohibit the intentional taking of human life, including physician-assisted suicide.

The Accreditation Council for Graduate Medical Education (ACGME) is a nonprofit, private association that evaluates residency programs, based on its own standards. However, the state in which St. Mary Hospital is located bases its accreditation of a hospital entirely upon the recommendation of the ACGME. The ACGME withdraws St. Mary Hospital's accreditation as a teaching hospital, concluding that its programs for training medical residents in geriatrics, oncology, and AIDS treatment are deficient because they do not include actual clinical instruction in physician-assisted suicide.

1) If St. Mary Hospital sues for return of its accreditation, will its claim under the Free Exercise Clause of the

---

[7] *See* Wardle, *supra*, at 218 ("[I]n practice, Title VII has provided limited and uneven protection for the rights of conscience of health care workers. Some courts have been grudging in their application of Title VII to health care employees disciplined because of their opposition to abortion.")

First Amendment be outweighed by the ACGME's argument that the government has an overriding interest in providing satisfactory physician education to residents?[8]

2) If St. Mary Hospital loses its accreditation, and thereby loses government funding and reimbursement (since a nonaccredited hospital generally cannot bill for government-funded health care), will it be able to remain open?

3) If medical training programs that refuse to provide actual clinical instruction in the administration of lethal drug dosages to patients are denied accreditation, will medical residents who desire a program in which they are not required to participate in clinical instruction in the administration of lethal dosages to patients be able to find such a program?[9]

If physician-assisted suicide is legalized, it is highly foreseeable that an attempt will be made to condition accreditation for all medical training programs upon the

---

[8] The above scenario draws upon an actual case in which a religiously-affiliated hospital lost accreditation for its medical residency training programs in obstetrics-gynecology for a variety of reasons, including its refusal for religious reasons either to provide clinical instruction in abortion or to allow its students to receive such training elsewhere. A federal district court denied the hospital's claim under the free exercise clause to an exemption from the requirements of the ACGME, which the court assumed was a state actor for purposes of licensing medical facilities. The court ruled that the state's interest in "satisfactory physician education" overrode the hospital's religious convictions against providing training in abortion. *St. Agnes Hospital of the City of Baltimore, Inc. v. Riddick*, 748 F. Supp. 319 (D. Md. 1990).

[9] *See* Wardle, *supra*, at 193, 221-222 (medical and nursing students are particularly vulnerable to pressure to participate in procedures to which they have moral or religious objections; students with such objections may be discriminated against in the admissions process or penalized during training, if they will not participate in morally controversial procedures.)

inclusion of clinical instruction in physician-assisted suicide. In 1995, the ACGME sought to impose on all medical training institutions a new accreditation standard requiring abortion training in all obstetrics/gynecological residencies. Diane M. Gianelli, *Legislators Seek to Bypass ACGME Abortion Training Rule*, American Medical News, July 17, 1995, at 1. Initially, the ACGME proposed standard required institutions that opposed abortion to make arrangements for residents who did not object to abortion to learn the procedure at another institution. *Id.* at 22. In response, in 1996, Congress prohibited the federal, state, and local governments from discriminating against a health care professional, a hospital, or a residency program because of the person's or entity's refusal to perform, train in the performance of, or make referrals for training in or performance of abortions. 42 U.S.C. § 245(a)(1) (1996). The law specifically provides that residency programs must be accredited if they meet all criteria for accreditation except for a requirement that it train in the performance of induced abortions. 42 U.S.C. § 245(b)(1) (1996).

B. The Courts Below Failed to Adequately Consider the Rights of Conscience of Medical Care Professionals.

The Ninth Circuit casually addressed the deadly dilemma its decision would force upon many physicians when it wrote:

> Recognizing the right to "assisted-suicide" would not require doctors to do anything contrary to their individual principles. A physician whose moral or religious beliefs would prevent him from assisting a patient to hasten his death would be free to follow the dictates of his conscience.

Wash.App. A96.

The court's assertion is completely unsupported in the opinion itself or in reality. The court leaves not only

physicians, but also less-empowered health professionals, at the mercy of supervisors who have the authority to issue orders that they assist in patients' suicides. Physicians will face increased malpractice litigation as physician-assisted suicide becomes the accepted standard of care for all physicians, even those with religious objections. Nor does the decision protect religiously-affiliated health care facilities from state regulations or private lawsuits requiring such treatment.

Ironically, in its decision, the Ninth Circuit relied heavily on language from *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992), suggesting that "the most intimate and personal choices" and "choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." Wash.App. A27. If this standard covers ending one's life by assisted suicide, as the Ninth Circuit holds, then it certainly must cover not having to participate in another's suicide. Assisted suicide, by definition, is not a lone act: It requires one or more assistants. No one should be forced to aid in killing, even if that assistance is necessary for persons desiring to kill themselves – as it most certainly will be for many hospital and nursing-home patients.

An analogous dilemma has already arisen in the context of persons seeking to terminate life-sustaining medical treatment. Some courts have been forced to deal with difficult cases where patients or families request the termination of certain life-sustaining treatments at institutions ethically committed not to deliver such treatments. *See, e.g., Brophy v. New England Sinai Hospital*, 497 N.E.2d 626, 639 (Mass. 1986); note 5, *supra*. Other courts have confronted cases arising where nurses or other health-care providers refused on ethical grounds to participate in nontreatment procedures. *See, e.g., Farnam v. Crista Ministries*, 807 P.2d 830 (Wash. App. 1991) (nurse refused to participate in the withdrawal of life-sustaining treatment for an incompetent patient). Such cases will surely multiply when the so-called medical procedure involves actively hastening death rather than allowing death to

occur. Many physicians and medical ethicists see a bright ethical and moral line dividing the two situations, and will refuse to cross that line under any circumstances.[10]

Following the *Farnam* case, Washington state lawmakers added the following provision to Washington's living-will statute:

> No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's . . . refusal to participate in the withholding or withdrawal of life-sustaining treatment.

1992 Wash. Laws, ch. 98, sec. 6. At the very minimum, the court below should have insured similar fundamental protection for the freedom and conscience of all health-care personnel and institutions when it created a right to assisted suicide.[11]

---

[10] *See, e.g.*, Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988). *See also*, discussion at pp. 18-21, *infra*.

[11] Drafting, and then passing, comprehensive language that will truly protect health workers' conscience rights will be difficult. As Professor Wardle concluded after surveying the current state and federal "conscience clauses":

> The current patchwork of state and federal conscience clause laws are well-intentioned but obviously and profoundly inadequate. . . . Virtually all are too narrow, cover too few health care providers, in too few situations, are too easily circumvented, and provide inadequate remedies and procedures to be effective. The deficiencies of these statutes have been compounded by the grudging interpretation given such provisions by many courts.

Wardle, *supra*, at 226. Professor Wardle offers a model "Health Care Providers' Rights of Conscience Protection Act." *Id.* at 227.

Protecting the right of health-care institutions, as well as individual practitioners, to refuse to assist patients in committing suicide ensures not only the freedom and conscience of persons working at those institutions, but also shields the freedom and conscience of patients served in them. Opponents of physician-assisted suicide reasonably fear that, if the practice is legalized, then it will lead to cases where patients are put to death without their full and free consent. *See* Yale Kamisar, *Against Assisted Suicide – Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735 (1995). Indeed, in the Netherlands, the only country where physician-assisted suicide is openly practiced, many cases have been documented in which involuntary euthanasia has occurred despite rules against it and procedures theoretically designed to prevent its occurrence. *See* Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*, 104-13 (1991).[12]

If physician-assisted suicide were legalized in the United States, persons needing hospital or nursing-home care would need to be assured the realistic option to choose an institution where that practice could never happen to them, even when they were weakest and unawares. These important concerns underscore the dangers associated with physician-assisted suicide, and why it is reasonable (indeed compelling) for states to outlaw the practice.

---

[12] The 1996 report, *Physician Assisted Suicide and Euthanasia in the Netherlands*, to the Subcommittee on the Constitution of the House Committee on the Judiciary, describes one account of a doctor allegedly "terminat[ing] the life of a nun a few days before she otherwise would have died because she was in excruciating pain, but her religious convictions did not permit her to ask for death." *Physician Assisted Suicide* Report, *supra*, at 19. The report concluded that "the doctor had as little respect for the right to self-determination as he had for religious freedom." *Id.*

II. The Second Circuit Wrongly Equated Terminating Life-Sustaining Medical Treatment with Prescribing Lethal Medication in Establishing an Equal Protection Right to Assisted Suicide.

In *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), the Second Circuit correctly identified "rational basis scrutiny" as the appropriate standard of judicial review under the Equal Protection Clause of the Fourteenth Amendment for statutes outlawing assisting suicide. However, on the crucial issue of equating types of terminally ill persons, the panel wrote that "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescription drugs." N.Y.App. 29a-30a. Yet the panel's opinion offered no medical, ethical, or historical authority – indeed, no authority of any type other than its own reasoning from prior decisions – for equating the two groups.

The absence of authority here is telling because it involves a central issue in medical ethics. Although some modern medical ethicists and physicians agree with the panel's conclusion,[13] the great weight of authority maintains that there is a fundamental difference between allowing patients to die by withdrawing or withholding medical treatment and hastening death through medical intervention. This distinction dates at least as far back in Western medical tradition as the ancient Hippocratic Oath. Referring to this oath, this Court once observed, "It represents the apex of the development of strict [ethical] concepts in medicine, and its influence endures to this day." *Roe v. Wade*, 410 U.S. 113, 131 (1973). Under the Hippocratic Oath, which is attributed to the 4th century

[13] *See, e.g.*, Marcia Angell, *Euthanasia*, 319 New Eng. J. Med. 1348, 1350 (1988).

B.C. Greek physician Hippocrates, a physician may refrain from treating patients but may never prescribe any "deadly medicine," even if asked.[14]

A. Physicians and Medical Ethicists Today Distinguish Between Hastening Death and Allowing to Die.

The major Anglo-American professional associations of physicians vigorously maintain this distinction today. Thus, for example, the American Medical Association condemns physician-assisted suicide as "contrary to that for which the medical profession stands" while it condones the withdrawal of life-sustaining treatment if it is in accordance with "the decision of the patient and/or his immediate family."[15] The British Medical Association assumed a similar stance in its 1988 *Euthanasia Report*, which concluded, "There is a distinction between an active intervention by a doctor to terminate life and a decision not to prolong life (a nontreatment decision)."[16]

Leading medical ethicists also accept this distinction. For example, the Hastings Center, a prominent national institute for the study of medical ethics, concluded in a

[14] The text of the Hippocratic Oath is widely reprinted, with this quote taken from the Oath as reprinted in Donald D. Millikin, *Oath of Hippocrates*, in 12 Collier's Encyclopedia 137 (1994). For commentary on this distinction, *see* Gaylin et al., *supra*, at 2139.

[15] Quoted from a 1973 resolution of the American Medical Association House of Delegates, reprinted in Thomas D. Sullivan, *Active and Passive Euthanasia: An Impertinent Distinction?*, in *Euthanasia: The Moral Issue* 53, 54 (Robert M. Baird & Stuart E. Rosenbaum, eds. 1989). For reference to a similar position taken by the Judicial Council of the American Medical Association in 1986, see Gaylin et al., *supra*, at 2139.

[16] *Conclusions of a British Medical Association Review of Guidelines on Euthanasia*, in *Euthanasia*, *supra*, at 155.

1987 report that helped shape the right to refuse life-sustaining treatment:

> Some persons who accept this right of patients to decide to forego treatment are concerned nevertheless that the values supporting it, and in particular self-determination, necessarily imply that voluntary euthanasia and assisted suicide are also justified. We disagree. Medical tradition and customary practice distinguish in a broadly accepted fashion between the refusal of medical intervention and intentionally causing death of assisting suicide.

Hastings Center, *Guidelines on the Termination of Life-sustaining Treatment and the Care of the Dying* 129 (1987). Four of America's premier physician-ethicists, Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, jointly declared on this point, "Generations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments (or allowing to die) and active, willful, taking of life." Gaylin et al., *supra*, at 2139. In a statement that utterly undermines the Ninth Circuit's position, these four scholars added, "Neither legal tolerance nor the best bedside manner can ever make medical killings medically ethical." *Id.*[17]

---

[17] An exhaustive study of the issue by the official New York State Task Force on Life and the Law reached a similar conclusion in 1994. New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994). Also in 1994, in the litigation spawned by Dr. Jack Kevorkian's practice of physician-assisted suicide, a Michigan appellate court accepted this distinction in the context of considering the constitutionality of a state law against assisted suicide. *Hobbins v. Attorney General*, 518 N.W.2d 487, 493 (Mich. App. 1994). For a fuller discussion of this distinction in the context of the Washington State statute at issue in the present case, see Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 Seattle U. L. Rev. 509, 516-19 (1995).

Given the overwhelming weight of medical and ethical authority against its position, it is understandable that the decision below does not cite any medical or ethical authority for equating physician-assisted suicide with terminating life-sustaining medical treatment. Physicians and medical ethicists typically view the two situations as fundamentally different.

B. The Second Circuit Gave an Inadequate Basis for Equating Physician-Assisted Suicide With the Right to Refuse Treatment.

The *only* evidence that the panel offered to support its equal-protection holding was the citation of New York State statutory and common law regarding the right of terminally ill persons to refuse life-sustaining treatment. It then quoted Justice Scalia's concurring opinion in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 297 (1990) (Scalia, J., concurring), as authority for dismissing "the action-inaction distinction" as irrelevant, leading to its conclusion that there is no legally meaningful distinction between "ordering the discontinuance of . . . artificial life-sustaining processes" and "writing a prescription to hasten death." *Quill*, N.Y.App. 30a. In both cases, the panel wrote, "The ending of life by these means is nothing more nor less than assisted suicide." *Id.* Justice Scalia's comment, of course, did not address the latter act and, as noted above, mainstream medical and ethical opinion simply does not equate the two actions. As the 1987 Hastings Center report concluded, "a reasonable, if not unambiguous, line can be drawn between foregoing life-sustaining treatment on the one hand, and active euthanasia or assisted suicide on the other." Hastings Center, *supra*, at 6.

The Second Circuit panel ignored this line and wrongly ordered the state to do likewise. Either the distinction between withdrawing life-sustaining treatment and prescribing lethal medication is sufficient to satisfy rational basis scrutiny, or many of America's most

respected medical ethicists and physicians are irrational regarding an issue of central concern to their profession.

III. The Ninth Circuit Wrongly Characterized the Early Historic Opposition to Suicide Within the Christian Tradition in Establishing a Due Process Right to Assisted Suicide.

In *Quill*, the Second Circuit panel set forth the appropriate tests for determining whether a right to assisted suicide constitutes a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment. Of course, a right to assisted suicide has no direct textual support in the language of the Constitution. With respect to such claimed rights, the panel observed:

> Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed. . . . " Fundamental liberties also have been described as those that are "deeply rooted in this Nation's history and tradition."

Quill, N.Y. App. 17a (citations omitted).

The Second Circuit panel concluded that neither of these tests were satisfied regarding a right to assisted suicide. "Indeed, the very opposite is true," the panel wrote, adding as follows:

> The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. . . . Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. . . . Clearly, no 'right' to assisted suicide ever has been recognized in any state in the United States.

Id. at 18a-19a (citations omitted). Based on this historical record, the panel declined the invitation to create a substantive due process right to assisted suicide. In doing so, it quoted the Supreme Court's apt warning, "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Id.* at 19a, *quoting Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).

The Ninth Circuit did not exercise such reasoned restraint. The majority *en banc* opinion reversed a prior ruling by a three-judge appellate panel that, like the Second Circuit panel, found "that 'a constitutional right to aid in killing oneself' was 'unknown to the past.'" *State of Washington*, Wash.App. A39 (quoting *Compassion in Dying v. State of Washington*, 49 F.3d 586, 591 (9th Cir. 1995)). Responding expressly to this finding, and implicitly to the Second Circuit panel, the *en banc* opinion stated that "our inquiry is not so narrow. Nor is our conclusion so facile. The relevant historical record is far more checkered than the [panel] majority would have us believe." *Id.* In an apparent effort to provide a traditional foundation for a right to assisted suicide, the Ninth Circuit then presented its own view of the relevant history, including the suggestion that early Christians accepted suicide. We leave it to other *amici* to critique the entire history, but wish to correct the record regarding the historic Christian view of suicide.

A. Contrary to the Suggestion of the Ninth Circuit, Early Christians Firmly Repudiated Suicide.

There was no moral acceptance of suicide within the early Christian church. Beth Spring & Ed Larson, *Euthanasia: Spiritual, Medical, and Legal Issues in Terminal Health Care* 105-19 (1988). No recognized historian has documented instances of early Christian church leaders condoning suicide, as that term is commonly understood, the voluntary taking of one's own life. Quite to the contrary,

they uniformly condemned self murder. *See, e.g.*, Robert Barry, *The Development of the Roman Catholic Teachings on Suicide*, 6 Notre Dame J.L., Ethics & Pub. Pol'y 466-468 (1995); Darrel W. Amundsen, *The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide, in Physician-Assisted Suicide: Ethics, Medical Practice, and Public Policy* (R.F. Weir, ed., 1997).

Even the Ninth Circuit opinion recognized that the influential bishop and Christian scholar Augustine (354-430 A.D.) denounced suicide as a "detestable and damnable wickedness" and that thereafter "the Christian view that suicide was in all cases a sin and crime held sway for 1,000 years." *State of Washington*, Wash.App. A43-44. But the court majority suggested that Augustine's opposition turned the Christian Church against a previously tolerated practice. *Id.* Yet the historical record shows consistent Church opposition to suicide from the earliest days. Regarding the pre-Augustinian period, one scholar recently observed:

> The early orthodox Christian church issued few official moral condemnations of suicide, or of any action for that matter, even though the great proportion of early Christian writers condemned deliberate self-killing vigorously. The lack of "official" condemnations of suicide, however, does not mean that the early Church endorsed or permitted it. The early Church produced many theological and moral writings against suicide, and these views later came to be expressed in councillor and juridical documents after Constantine granted legal status to the Church.

Barry, *supra*, at 467 (footnote omitted).

The notable pre-Augustinian moral and theological writings by recognized Church leaders condemning the practice of suicide include ones by Clement of Alexander (ca.155-ca.220 A.D), Tertullian (ca. 160-ca.220 A.D.), Basil of Caesarea (ca.330-379 A.D.), and Jerome (ca.342-419 A.D.), as well as the anonymous "Epistle to Diognetus"

and Clementine "Homilies." *Id.* at 467 n. 101. The great Church leader Justin Martyr (ca.100-165 A.D.) wrote that suicide "will be opposing the will of God."[18] In his *Divine Institutes*, the theologian Lactantius (ca.240-320 A.D.) commented on suicide that "nothing can be more wicked than this."[19] Bishop John Chrysostom (349-407 A.D.) affirmed that "if it is base to destroy others, much more is it to destroy one's self."[20] Milan's noble-born scholar-bishop, Ambrose (ca. 339-397 A.D.), advised "that holy Scripture forbids a Christian to lay hands on himself."[21]

Further evidence for early Christian opposition to suicide is demonstrated by the rapidity with which the practice passed from public tolerance as Christianity spread throughout the Roman world. One of the leading authorities cited by the Ninth Circuit, Thomas Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1 (1985), notes:

> The gradual dominance of Christianity in the Roman Empire, culminating in the conversion of the Emperor Constantine in the 4th century A.D., worked a transformation in the cultural attitude toward suicide. Imbuing all strata of the Roman world with its spiritual principles, Christianity provided a view of life that was itself inimical to suicide.

Id. at 26. Once common suicide practices, such as disgraced generals falling on their swords, virtually vanished. Barry, *supra*, at 466. The infanticide of unhealthy or

---

[18] Justin Martyr, 2 *Apology* 4, in 6 *Fathers of the Church* 123 (1948).

[19] Lactantius, *Divine Institutes* 3.18, in 7 *Ante-Nicene Fathers* 89 (1951).

[20] John Chrysostom, *Commentary on Galatians* 1:4, in 13 *Select Library of Nicene and Post-Nicene Fathers of the Christian Church* 5 (1977).

[21] Ambrose, *Concerning Virgins* 3.7.32, in 10 *Select Library, supra*, 2d ser., 386 (1979).

unwanted children was absolutely proscribed for the first time. Rodney Stark, *Rise Of Christianity* 124 (1996). In deeds as well as words, early Christians rejected suicide and euthanasia.

In contrast to the consistent historical record of early Church opposition to suicide, the Ninth Circuit writes, "The early Christians saw death as an escape from the tribulations of a fallen existence and as the doorway to heaven." Wash.App. A42. Yet the authority cited by the court for this view went on to state that, even though the Bible "contains no explicit prohibition against suicide," nevertheless, "the early Christians incorporated Judaic attitudes and Platonist philosophy which both opposed the practice." Marzen, *supra*, at 26. In particular, the Ninth Circuit cites the early Christian martyrs, who died rather than renounce their faith, as examples of the acceptance of suicide among early Christians, and quotes from a 200-year-old history of the Roman Empire to describe the nature and extent of the practice. Wash.App. A42-43. Yet submitting to forced martyrdom is not equivalent to modern practices of voluntary suicide, and modern scholarship suggests that earlier historians grossly exaggerated both the number of early Christian martyrs and the eagerness with which they met their fate. *See, e.g.*, Stark, *supra*, at 179-184. Indeed, as noted above, one of the most famous early Christian martyrs, Justin, preached and taught against suicide.

The Ninth Circuit also turns to the Bible to support its position. Here too, however, its reliance is misplaced. The court wrote:

> The stories of four suicides are noted in the Old Testament – Samson, Saul, Abimlech [sic], and Achitophel [sic] – and none is treated as an act worthy of censure. In the New Testament, the suicide of Judas Iscariot is not treated as a further sin, rather as an act of repentance.

Wash.App. A42 n. 25. Actually, there are other examples of suicide recorded in the Bible, but many more examples of faithful Jews and Christians resisting the temptation to

commit suicide. *See* Barry, *supra*, at 454-58. Of the five Biblical suicides identified by the Ninth Circuit, all but Samson were persons utterly alienated from God, and Samson died as a captured warrior in an act intended to kill Israel's enemies. *Id.*, at 452-457. Saul attempted to kill himself by falling on his sword, after losing God's favor and losing in battle. However, his fall on his sword left him "in the throes of death," and he begged an Amalekite soldier to kill him. 2 *Samuel* 1:9. The Amalekite "stood over him and killed him, because I knew that after he had fallen he could not survive." 2 *Samuel* 1:10. King David had the Amalekite killed for his killing of Saul. 2 *Samuel* 1:15-16. This would seem to suggest that assisted-suicide was not met with approval, at least by King David. Like Saul, Abimelech also disobeyed God as a leader of Israel: He murdered his 70 brothers and later asked to be killed after suffering a mortal wound. *Judges* 9:54. Ahithophel was a disloyal counselor to David who strangled himself after his treason was discovered. 2 *Samuel* 17:21-23. Judas hanged himself after betraying Christ, which Marzen notes with mock understatement "hardly recommended suicide to the early Christian church." Marzen, *supra*, at 26. These are not models for Christian behavior, and their suicides underscored their depravity. *See, e.g.*, Barry, *supra*, at 456-57. There simply is no Biblical acceptance of suicide.

In claiming an ancient acceptance of suicide, the Ninth Circuit relied on the writings about suicide of Alfred Alvarez and Emile Durkheim. Wash.App. A42. Neither was an historian, however. Alvarez, who wrote in defense of suicide, is a poet who writes of himself that he "began as a literary critic, but by the end of the 1960s had grown weary of writing books about other people's books, so effectively gave up criticism in order to concentrate on his own creative work." Alfred Alvarez, in 33 *Contemporary Authors*, n. ser. 6 (1991). One might suspect his history as being a creative effort. *See, e.g.*, Darrel W. Amundsen, *Did Early Christians "Lust After Death"?* 12 Christian Research J. (Spring, 1996). Durkheim was a

preeminent nineteenth century French sociologist who devised and utilized a broad definition of suicide that included, in his own words, "All cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." Emile Durkheim, *Suicide: A Study in Sociology* 44 (J.A. Spaulding and G. Simpson, trans., 1951). Thus, for Durkheim, suicides included soldiers and martyrs who knowingly gave their lives for political or religious causes – a subjective desire to die was irrelevant. *See id.* at 227. The writings of Alvarez and Durkheim do not provide historical support for early Christian acceptance of the type of suicide at issue in this case.

The Ninth Circuit's attempt at Biblical interpretation illustrates the danger of judicial interpretations of religious doctrine. It is hard to "imagine a subject less amenable to the competence of the federal judiciary, or more deliberately to be avoided where possible." *Lee v. Weisman*, 112 S. Ct. 2649, 2671 (1992) (Souter, J., concurring).

B. The History and Tradition of the Nation and the State of Washington Firmly Oppose Any Right to Assisted Suicide.

The test that the Ninth Circuit apparently is trying to satisfy with its analysis of historical attitudes toward suicide describes fundamental liberties as those that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977). *See Griswold v. Connecticut*, 381 U.S. 479, 506 (1965) (White, J., concurring). By its terms, this test looks only to American history and tradition – which is what the Second Circuit panel did in finding no right to assisted suicide under the Due Process Clause. *Quill*, N.Y.App. 18a-19a. The same result should follow for the Washington State law against assisting suicide at issue in the Ninth Circuit case. If the history and tradition of this statute are any guide, they strongly support upholding it as constitutional.

Restrictions against assisting suicide were in place in Washington even before the region became a state. The second bill passed by the first territorial legislature for Washington, in 1854, provided, "Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter." 1854 Wash. Laws p. 78, § 17. That law or one similar to it has remained on the books in Washington ever since. *See* 1869 Wash. Laws p. 201, § 17; 1873 Wash. Laws, p. 184, § 19; and 1909 Wash. Laws, ch. 249, § 135.

In its present form, the Washington law also reflects the relatively recent influence of the Model Penal Code, which was crafted by the leading criminal law scholars of the mid-twentieth century. Stanford Kadish, *The Model Penal Code's Historical Antecedents*, 19 Rutgers L.J. 521 (1988). The drafters of the Model Penal Code considered the arguments in favor of decriminalizing assisting suicide, but ultimately decided to retain that traditional feature of Anglo-American criminal law. In the commentary to the Code, the drafters noted that "the interests in the sanctity of life that are represented by the criminal homicide law are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." American Law Institute, *Model Penal Code and Commentaries*, I, 100 (1985). Indeed, it is difficult to think of a more effective way of discouraging suicide than to stop others from helping the victim.

In the past thirty years, following the publication of the Model Penal Code, eight states passed new statutes specifically outlawing assisted suicide and eleven other states, including Washington in 1975, revised their existing statutes. Marzen, *supra*, at 100. In 1991, Washington State voters rejected an initiative measure that would have legalized physician-assisted suicide.[22] A year later,

---

[22] *See* N.Y. Times, Nov. 7, 1991, sec. B, at 16.

the Washington State legislature added a provision expressly excluding physician-assisted suicide from the state's advance-directives statute. 1992 Wash. Laws, ch. 98, sec. 10. In short, the history of the Washington State law against assisting suicide demonstrates an acceptance of such statutory bars that is deeply rooted in both the Nation's and the State's history and tradition.[23]

CONCLUSION

For the above reasons, the decisions below should be reversed.

Respectfully submitted,

EDWARD J. LARSON*
KIMBERLEE WOOD COLBY
STEVEN T. MCFARLAND
Center for Law and
Religious Freedom
Christian Legal Society
4208 Evergreen Lane, Suite 222
Annandale, Virginia 22003
703-642-1070

Counsel of Record

[23] For a fuller analysis of the history of the Washington State law against assisting suicide, see Edward J. Larson, *Prescription for Death: A Second Opinion*, 44 DePaul L. Rev. 461, 462-66 (1995).

APPENDIX

INTERESTS OF THE *AMICI*

The **Christian Legal Society** ("CLS"), founded in 1961, is a nonprofit ecumenical professional association of 4,000 Christian attorneys, judges, law professors, and law students with chapters in every state and at 85 law schools. CLS' legal advocacy and information arm, the Center for Law and Religious Freedom, defends religious exercise and the sanctity of human life in state and federal courts at all levels.

The Society is committed to religious liberty because the founding instrument of this nation acknowledges as a "self-evident truth" that all persons are divinely endowed with rights that no government may abridge nor any citizen waive. Declaration Of Independence (1776). Among such inalienable rights are those enumerated in (but not conferred by) the First Amendment, the first and foremost of which being religious liberty. The right sought to be upheld here inheres in all persons by virtue of its endowment by the Creator, Who is acknowledged in the Declaration. It is also a "constitutional right," but only in the sense that it is recognized in and protected by the U.S. Constitution. Because the source of religious liberty, according to our nation's charter, is the Creator, not a constitutional amendment, statute or executive order, it is not merely one of many policy interests to be weighed against others by any of the several branches of state or federal government. Rather, it is foundational to the framers' notion of human freedom. The State has no higher duty than to protect inviolate its full and free exercise. Hence, the unequivocal and non-

negotiable prohibition attached to this, our First Freedom is "Congress shall make **no** law. . . . "

The **Christian Medical and Dental Society** ("CMDS") was founded in 1931 and today represents over 10,500 members – primarily practicing physicians representing the entire range of medical specialties. These members share a common commitment to the principles of biblical faith and the integration of those principles with professional practice. Among other functions, the CMDS Medical Ethics Commission gathers together member experts in the field of medical ethics who formulate positions on vital issues. These positions are subsequently voted upon for adoption, amendment, or rejection by over 100 elected representatives to the national convention of the Society.

CMDS has through this democratic process arrived at a life-honoring consensus among the membership on the issue of physician-assisted suicide. CMDS views this life-honoring principle as essential to protecting the lives and best interests of our patients, practicing medicine conscientiously according to long-standing Hippocratic and religious principles, and preserving the public respect accorded to physicians as guardians of health and life.

The **Nurses Christian Fellowship** was founded in 1948 and is a department of InterVarsity Christian Fellowship. It represents approximately 2000 nurses and publishes *The Journal of Christian Nursing*, which has over 9000 subscribers. The Nurses Christian Fellowship represents nurses who are students and faculty in schools of nursing, and nurses who work in hospitals, long-term care facilities, and health agencies in the community.

The **Christian Pharmacists Fellowship International** (CPFI) was incorporated as a non-profit group of Christian pharmacists in 1984 with the express purpose of promoting the integration of Biblical principles into the global practice of pharmacy. CPFI has 1000 professional members, consisting of those practicing all branches and specialties within the field of pharmacy. The position taken in this brief is consistent with a position paper filed by CPFI, published in the October, 1996 issue of *The Annals Of Pharmacotherapy*.

The **Fellowship of Christian Physician Assistants,** founded in 1980, has 700 member physician assistants. Working with physician supervision in hospitals, long-term care facilities, and clinical settings, physician assistants provide physician services, including highly technical services, in all medical specialties. The members of the Fellowship of Christian Physician Assistants are certain that physician assistants will be routinely delegated the task of carrying out the orders for physician-assisted suicide.
